TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
OCCUPATIONAL MEDICAL CARE

Respondent Name
FEDERAL INSURANCE CO

MFDR Tracking Number
M4-16-0186-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
September 18, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Occupational Medical Care is disputing INSURANCE COMPANY'S denial on the above claim. We request a resolution based on the fact that we believe the procedure codes are all valid codes. INSURANCE COMPANY claims that they did not receive our bill for date-of-service listed above; therefore, we refilled the claim providing proof-of-timely filing and which resulted in a denial for timely filing. Please find the attached report from our electronic billing website to show that the bills were sent over and received within the 95 day filing range."

Amount in Dispute: $219.23

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This letter is in regards to the Medical Dispute Request Occupation Medicare Care for services rendered on 7/8/2014. The services were denied for timely filing as the carrier received date exceeded the 95 days from date of service.

The original bill was received by the carrier on 7/6/2015 via fax. The carrier received date was incorrectly entered into the bill review software from a date stamp reflecting 7/6/2015. The bill was reviewed and denied for timely filing. The date of service was from a year before on 7/8/2014."

Response Submitted by: WellComp

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 08, 2014	CPT Code 99203, 99080-73, L3999 and A9900	$219.23	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 29 – The time limit for filing has expired
   - 16 – Claim/service lacks information which is needed for adjudication. Remark codes whenever appropriate

Issues

1. Did the requestor waive the right to medical fee dispute resolution?

Findings

1. 28 Texas Administrative Code §133.307(c)(1) states:

   Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section.

   (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute.

   The date of the services in dispute is July 08, 2014. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on September 18, 2015. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307(c)(1)(B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		10/16/15
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.